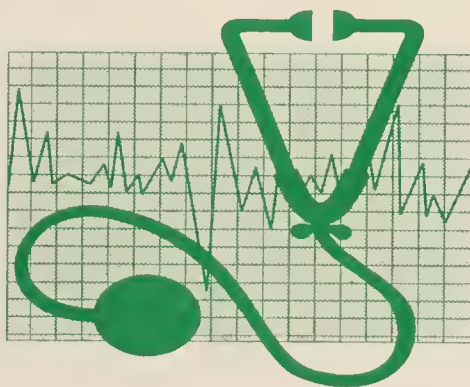


S
368.382
A14mbg
1998?
c.1

Montana buyers
guide to Medicare
supplement
insurance

MONTANA BUYERS GUIDE TO MEDICARE SUPPLEMENT INSURANCE



STATE DOCUMENTS COLLECTION

.III. 15 1998

MONTANA STATE LIBRARY
1515 E. 6th AVE.
HELENA, MONTANA 59620

PLEASE RETURN

Mark O'Keefe

State Auditor
Insurance Commissioner

MONTANA STATE LIBRARY



3 0864 0014 0404 8

STATE AUDITOR
STATE OF MONTANA

Mark O'Keefe
STATE AUDITOR



COMMISSIONER OF INSURANCE
COMMISSIONER OF SECURITIES

I am pleased to provide you with a copy of the Montana Buyers' Guide to Medicare Supplement Insurance. This guide includes tips on choosing a Medicare supplement, the current coverages provided by Medicare, and, most importantly, a chart comparing many of the Medicare supplement policies being sold in Montana. After reading the Buyers' Guide, you should feel more comfortable making your decision on which Medicare supplement coverage will provide you with the best coverage based on your medical needs and budget.

This is the ninth edition of the Montana Buyers' Guide. Federal and state regulations require insurance companies to provide Medicare supplement policies that are limited to no more than 12 standard benefit plans. Each of the 12 plans must cover specific expenses. Policy "A" is the most basic policy and "J" is the most comprehensive. Each company's policies are alike. This will make it easier for you to compare plans and premiums.

If you have any questions regarding Medicare supplement policies or any other type of insurance, please contact my office. Our toll-free number for outside the Helena area is 1-800-332-6148 and 444-2040 in the Helena area.

Sincerely,

A handwritten signature in dark ink, reading "Mark O'Keefe".

Mark O'Keefe, State Auditor
and Commissioner of Insurance

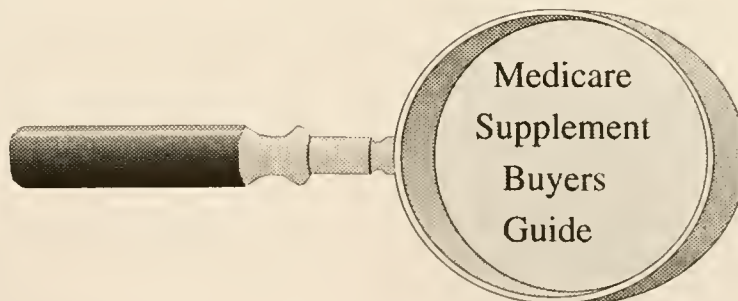


Digitized by the Internet Archive
in 2011 with funding from
Montana State Library

<http://www.archive.org/details/montanabuyersgui1998okee>

TABLE OF CONTENTS

Introduction	1
Current Benefits For Senior Citizens	3
Medicare Coverages	5
Medicare Chart	6
Project Part B Premiums/Prevention Benefits	8
Future Medicare Options	9
10 Standard Medicare Supplement Benefit Plans	10
Important Phone Numbers	11
Medicare Supplements for those Under Age 65	13
Buyer's Checklist	14
Shopping Tips	15
Definitions	17



INTRODUCTION

The **Montana Buyers' Guide to Medicare Supplement Insurance** is a joint effort of the Montana Insurance Department and the Insurance Counseling and Assistance Program of the Montana Office on Aging to assist seniors in understanding Medicare and Medicare supplement insurance.

WHAT IS MEDICARE?

Medicare is the federal health insurance program for those individuals 65 years of age or older, people of any age with permanent kidney failure, and certain disabled individuals under age 65.

WILL MEDICARE COVER ME IF I CONTINUE TO WORK AFTER AGE 65?

If your employer has more than 20 employees and provides health insurance for the employees, your group insurance may be your primary coverage until you quit your job.

WHAT ARE THE "GAPS"?

1. Part A and B deductibles
2. Copayments
3. Charges not covered by Medicare

WHAT IS PART A?

Part A of Medicare is primarily coverage for inpatient hospitalization. For a more in-depth description please see page 6.

WHAT IS A BENEFIT PERIOD?

A benefit period begins on the first day of a Medicare covered inpatient stay. It ends when you have been out of the hospital or skilled nursing facility for 60 consecutive days. If the beneficiary is hospitalized after 60 days, a new benefit period begins and the beneficiary must pay a new inpatient hospital deductible. There may be as many as five benefit periods in a calendar year.

WHAT IS PART B?

Part B of Medicare is called Medical Ins. and covers outpatient services. For a more in-depth description please see page 7.

WILL MEDICARE COVER ALL MEDICAL EXPENSES?

No. Medicare covers only a portion of health care costs for individuals. The reason for a Medicare supplement is to help with expenses not fully paid by Medicare.

DO SUPPLEMENTS COVER ALL CHARGES NOT PAID BY MEDICARE?

No. Supplements will not cover expenses if Medicare does not pay a part of the bill, except in certain instances. See the chart on page 10 under Plans F, G, I, J for exceptions.

WHAT IF MEDICARE CONSIDERS A SERVICE TO BE UNNECESSARY?

Physicians who recommend a procedure which they should be aware is not a covered charge by Medicare are required to notify you in writing that Medicare will not cover the service. Similarly, if a surgeon does not accept assignment for elective surgery, the physician must give you a written estimate if the charge will exceed \$500.

WHAT IS ASSIGNMENT?

If a provider accepts the charges allowed by Medicare as payment in full, he accepts assignment.

WHAT IS A LIMITING CHARGE?

Physicians who do not accept assignment are limited to charging 115% of the fee schedule for nonparticipating doctors.

WHAT IS ISSUE AGE?

The premium is set when you buy the policy. You continue to pay the premium required of a person of the same age you were when the policy was issued. For example, if you buy a policy at age 65, you will always pay the rate the company charges people who are 65, regardless of your current age.

IF I ALREADY HAVE A MEDICARE SUPPLEMENT, SHOULD I REPLACE IT WITH A NEW STANDARDIZED PLAN?

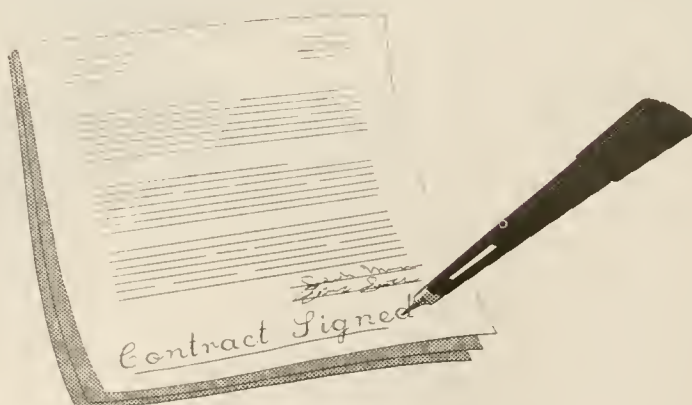
New is not necessarily better. Some of the Medicare supplements sold prior to OBRA 1990 standardization have more comprehensive benefits than the twelve new standardized plans. Carefully review your coverage before you replace your policy. It may be to your advantage to keep the old policy. Be aware, however, that these prestandardized plans may cost more as the population covered becomes older and in need of more health care insurance

HOW DO I KNOW HOW MUCH COVERAGE TO BUY?

It is important to know how to assess your need for insurance in every type of coverage you buy. In buying a Medicare supplement policy, you should review your medical care costs for the preceding year, assess your current health status, and choose a plan which is affordable. You may want to consider a policy with prescription coverage if you are currently taking medications. The cost of prescription drugs has increased dramatically in the last few years.

WHAT IS ATTAINED AGE?

The premium is based on your current age and increases automatically as you grow older. Typically, these plans will appear to be less expensive at younger ages, but they may cost considerably more in later years.



CURRENT BENEFITS FOR SENIOR CITIZENS

The Qualified Medicare Beneficiary Program and Spousal Impoverishment Program are available to assist seniors. These are important benefits if you have very limited income and assets, or if your spouse is in a long term care facility.

The Qualified Medicare Beneficiary Program (QMB) is designed to provide Medicare premiums, deductibles, and coinsurance for seniors with limited incomes. The amount of income is set for individuals and couples each year by the Federal government. To find out if your income qualifies, you may wish to contact the Human Resources office in your county. This program will not pay for expenses which are not allowed by Medicare.

Due to new federal regulations, you may suspend your Medicare supplement policy upon enrollment in the Qualified Medicare Beneficiary Program. You will need to notify your insurance company in writing of your eligibility for QMB within 90 days. If you lose your eligibility for the QMB you may reinstitute your Medicare supplement policy by notifying the insurer in writing and paying the premium within 90 days of the termination of eligibility.

The Specified Low Income Beneficiaries program assists individuals with slightly more income than those who are Qualified Medicare Beneficiaries by paying their Part B premiums each month. Individuals and couples with monthly income in a specific range set by the Federal government qualify. In addition to the income limit, financial resources, such as bank accounts, stocks and bonds cannot exceed \$4,000 for one person or \$6,000 per couple.

Under the Spousal Impoverishment Program, when a spouse enters a long term care facility, there are new rules for the division of assets for the spouse who remains at home. The spouse at home may retain a maximum of half of the couple's resources, not to exceed a maximum set by the federal government. In addition, certain assets are exempt such as the home in which they live, household goods, and one car. There are also new regulations concerning the amount of income the spouse at home may retain on a monthly basis.

Either spouse may request an assessment of resources when one spouse enters a nursing home. You will need to contact your county office for more information. The Qualified Medicare Beneficiary Program and the Spousal Impoverishment Program are very important additions for our seniors. We encourage you to find out more about these programs if you qualify.

OTHER COVERAGES

Medicare provides partial coverage of mammograms. Seniors must have one mammogram for screening purposes every 12 months. These mammograms must be performed by a certified facility and other restrictions may apply. Please see the chart on page 8 for additional coverages. Seniors may wish to check with Medicare prior to obtaining these services to determine the amount of coverage.

MEDICARE SUPPLEMENT STANDARDIZATION

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) included new standards for Medicare supplement insurance. As a result of this federal legislation, there are only twelve Medicare supplement policies available to purchase. These should facilitate the exact comparison of coverage and premiums. The standardized policies are described on page 10. The company information which follows will list the premium for each plan offered.

If you already have a Medicare supplement, you **do not need to replace it with a standardized policy**. Your old policy may have more benefits than a standardized policy. Review your coverage carefully before you replace your policy.

Seniors should be aware that their current prestandardized Medicare supplement may provide more coverage than the standardized policies. You will need to compare the outline of coverage for your current policy very carefully with the outline of coverage for the standardized plan to determine the differences in the policies.

OPEN ENROLLMENT

OBRA 1990 also requires insurance companies selling Medicare supplement insurance to issue policies to seniors who qualify for Medicare Part B due to attainment of age 65 without regard to their current health status. This open enrollment period is for 6 months beginning with eligibility for Part B of Medicare.

Companies may not refuse to issue a Medicare supplement to you or delay the issue of the policy based on your medical condition, health status, claims experience, or receipt of health care. The company may impose a 6 month pre-existing condition clause during the first 6 months of the policy.

If you delay enrollment in Part B of Medicare and are covered by a plan provided by your employer or your spouse's employer, you will have an open enrollment period starting with the month in which you are no longer covered by the employer's plan. Your open enrollment period will start when your Part B coverage becomes effective.

If you miss your open enrollment period contact your local Social Security Office. There may be a waiting period for coverage and premium payments due.

Some individuals are eligible for Medicare due to a disability and are under age 65. The open enrollment period applies to these individuals upon turning age 65.

PART B CHARGES

Health care providers are required to bill Medicare directly for beneficiaries. Amounts billed on Part B of Medicare may not exceed 115% of the Medicare allowable amount for 1993. The law requires physicians to refund excess charges over and above the 115% within 30 days.

MEDICARE COVERAGES

Medicare Hospital Insurance = Medicare Part A

Medicare pays for all but \$764 of your hospital stay in each benefit period for reasonable and necessary care in the first 60 days of confinement. For the next 30 days, Part A pays for all covered services except \$191 a day. The 91st through 150th days Medicare pays expenses in excess of \$382 a day. These are Lifetime Renewable Days and may only be used once. If you are hospitalized for over 150 days Medicare pays nothing.

A benefit period begins the first day of hospitalization and ends when you have been out of a hospital or skilled nursing facility for 60 consecutive days. Therefore, it is possible to have more than one benefit period and more than one hospital deductible in a calendar year.

Charges for skilled nursing facility stays may be paid by Medicare if the facility is a Medicare-certified facility. To qualify for this benefit, you must have been hospitalized for at least 3 days and have been admitted to the nursing facility within 30 days of discharge from the hospital. The first 20 days are covered at 100% provided you are receiving skilled care. The next 80 days Medicare pays amounts over \$95.50 a day. Beyond the 100th day, Medicare pays nothing.

Under certain conditions, home health care is available for homebound beneficiaries. This coverage includes skilled nursing services, occupational therapy, and physical and speech therapy if provided by a Medicare-certified home health service and if determined to be medically necessary. If your physician establishes a care program which requires durable medical equipment, Medicare will pay 80% of the Medicare-approved cost of the equipment, call 1-800-899-7095.

Medicare provides coverage for hospice care for patients certified as terminally ill. This benefit is divided into two 90-day hospice benefit periods and one 30-day benefit period. A subsequent extension may also be covered.

You pay for the first three pints of blood; Medicare pays for any additional blood.

Medicare Medical Insurance = Medicare Part B

Medicare covers services of a physician, outpatient hospital services, lab services, x-ray, radiation and therapy services, home health visits, physical therapy, speech pathology services, some forms of vaccinations, durable medical equipment, limited ambulance services, prosthetic devices, immunosuppressive drugs for the first year following an organ transplant, and other medical supplies and equipment. In 1998, the Part B premium is \$43.80 a month. You are not required to purchase Part B, but it is an excellent buy because the Federal government pays most of the actual cost.

The Part B deductible is the first \$100 of expense in a calendar year. After the deductible, Medicare pays 80% of the approved charges.

The Medicare deductible for blood expense is the cost for the first 3 pints of blood.

**MEDICARE (PART A): HOSPITAL INSURANCE-COVERED SERVICES
PER BENEFIT PERIOD FOR 1998**

SERVICES	BENEFIT	MEDICARE PAYS	YOU PAY
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but \$764	\$764
	61st - 90th day	All but \$191 a day	\$191 a day
	91st - 150th day*	All but \$382 a day	\$382 a day
	Beyond 150 days	Nothing	All costs
POSTHOSPITAL SKILLED NURSING FACILITY CARE: You must have been in a hospital for at least 3 days and enter a Medicare-approved facility generally within 30 days after hospital discharge.	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but \$95.50 a day	\$95.50 a day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE	Medically nec. skilled care, home health aide services, medical supplies etc.	Full cost of services; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
HOSPICE CARE Available to terminally ill.	As long as doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care
BLOOD	Unlimited during a benefit period if medically necessary.	All but 1st 3 pints per calendar year.	For first 3 pints

* Lifetime Reserve Days may be used only once.

**MEDICARE (PART B): MEDICAL INSURANCE-COVERED SERVICES
PER CALENDAR YEAR 1998 (Premium \$43.50)**

SERVICES	BENEFIT	MEDICARE PAYS	YOU PAY
MEDICAL EXPENSE Physician's services, inpatient and outpatient med. and surgical services and supplies, physical and speech therapy, diagnostic tests, therapy, diagnostic tests, durable medical equip., etc.	Medicare pays for medical services in or out of the hospital.	80 % of approved amount (after \$100 deductible).	\$100 deductible plus 20 % of approved amount (plus any charge above approved amount).
CLINICAL LABORATORY SERVICES	Blood tests, biopsies, urinalysis, etc.	Full cost of services.	Nothing for services.
HOME HEALTH CARE	Medically neces. skilled care, home health aide services, med. supplies, etc.	Full cost of services; 80 % of approved amount for durable medical equipment.	Nothing for services; 20 % of approved amount for durable medical equipment.
OUTPATIENT HOSPITAL TREATMENT	Unlimited if medically necessary.	80 % of approved amount (after \$100 deductible).	Subject to deductible plus 20 % of approved amount.
BLOOD	Unlimited if medically necessary.	80 % of approved amount (after \$100 deductible and starting with 4th pint).	For first 3 pints plus 20 % of approved amount for additional pints (after \$100 deductible).*

*To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

Projected Medicare Part B Premiums

	1997	1998	1999	2000	2001	2002	2003
Old Law	\$43.80	\$43.80	\$47.10	\$48.50	\$50.00	\$51.60	\$53.00
New Law	\$43.80	\$43.80	\$50.60	\$55.30	\$60.70	\$67.00	\$74.00

If your income is under about \$11,000* for an individual or \$14,700* for a couple, you may be eligible for assistance in paying your premium. Contact your state Medicaid program for more information.

***estimate**

Prevention Benefits

	1997	1998	1999	2000	2001	2002	2003
Mammograms	Covered Bi-Annually	Covered Annually	→	→	→	→	→
Pap Smears	Covered Every 3 Years	Covered Annually*	→	→	→	→	→
Prostate Cancer Screening	Not Covered			Coverage Begins	→	→	→
Colorectal cancer Screening	Not Covered	Coverage Begins	→	→	→	→	→
Diabetes Self- Management	Not Covered	Coverage Begins	→	→	→	→	→

***For high-risk women**

Future Medicare Options

	1997	1998	1999	2000	2001	2002	2003
Options	Choice of traditional Medicare or HMOs	Choice of traditional Medicare, managed care plans, and new private fee-for-service	Choice of medical savings accounts (MSAs) option added; experimental program limited to 390,000 enrollees	→	→	→	→
Enrollment	Option to change plans on a monthly basis	→	→	→	→	One six-month period each year in which to change plans	One three-month period each year in which to change plans

Traditional Medicare - You visit any doctor that takes Medicare. You may also buy a supplemental policy to pay for services and costs allowed but not paid by Medicare.

Managed Care Plans - Includes a range of plans such as health maintenance organizations (HMOs), Point-of-Service (POSs), Preferred Provider Organizations (PPO) and Provider Sponsored Organizations (PSOs), that limit the list of doctors you can see, but often offer extra benefits.

Private Fee-For-Service - You can visit any doctor or purchase any health plan but you pay extra for uncovered or expensive services.

Medical Savings Account (MSAs) - Medicare would provide you with a high deductible catastrophic insurance policy and advance you a portion of the high deductible. At the end of the year, you may keep any unused Medicare money.

12 STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS

CORE BENEFITS	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan F*	Plan G	Plan H	Plan I	Plan J	Plan J*
Part A Hospital (Days 61-90)	X	X	X	X	X	X	X	X	X	X	X	X
Lifetime Reserve (Days 91-150)	X	X	X	X	X	X	X	X	X	X	X	X
365 Life Hosp. Days-100 %	X	X	X	X	X	X	X	X	X	X	X	X
Parts A and B Blood	X	X	X	X	X	X	X	X	X	X	X	X
Part B Coinsurance-20 %	X	X	X	X	X	X	X	X	X	X	X	X
ADDITIONAL BENEFITS	A	B	C	D	E	F	F*	G	H	I	J	J*
Skilled Nursing Facility Coinsurance (Days 21-100)			X	X	X	X	X	X	X	X	X	X
Part A Deductible		X	X	X	X	X	X	X	X	X	X	X
Part B Deductible			X			X	X				X	X
Part B Excess Charges						100 %	100 %	80 %		100 %	100 %	100 %
Foreign Travel Emergency			X	X	X	X	X	X	X	X	X	X
At-Home Recovery				X				X		X	X	X
Prescription Drugs									1	1	2	2
Preventive Medical Care					X						X	X

Core Benefits pay the patient's share of Medicare's approved amount for physician services (20 %) after \$100 annual deductible, the patient's cost of a long hospital stay (\$184/day for days 60-90, \$368/day for days 91-150, all approved costs not paid by Medicare after day 150 to a total of 365 days lifetime), and charges for the first 3 pints of blood not covered by Medicare.

Two prescription drug benefits are offered:

1. a "basic" benefit with \$250 annual deductible, 50 % coinsurance, and a \$1,250 maximum annual benefit (Plans H and I above), and
2. an "extended benefit (Plan J above) containing a \$250 annual deductible, 50 % coinsurance, and a \$3,000 maximum annual benefit.

*Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year (\$1500) deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are (\$1500). Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but does not include, in Plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible.

Important Phone Numbers



Durable Medical Equipment: Durable Medical Equipment Regional Carrier -- 1-800-899-7095

Home Health Care Offices: 515-245-4834

Insurance Counseling and Assistance:
Call 1-800-332-2272

Medicaid: 1-800-624-3958 / 406-442-1837

Medicare eligibility, a new Medicare card, or want information on how to get on Medicare:

Call your local Social Security Office listed below or the toll-free number: 1-800-772-1213

Billings	1-800-543-0524	Havre	265-5472
Bozeman	586-4501	Helena	441-1275
Butte	782-6725	Kalispell	755-1015
Glasgow	228-8272	Missoula	251-5034
Great Falls	761-0661	Premium Problems	1-800-833-6364

Medicare Part A: 406-791-4086 for hospital claim questions

Medicare Part B: 406-444-8350 or 1-800-332-6146 for questions regarding physician claims

Montana Insurance Commissioner: 1-800-332-6148 for questions about insurance

MONTSHARE is a program that is designed to improve access to medical care for seniors experiencing financial difficulties. This program was initiated by local physicians, hospitals and the Montana Medical Association. Under MONTSHARE, physicians are asked to accept Medicare assignment. If you think you qualify, call 1-800-426-3167.

Peer Review Organization (PRO): If you think you have a problem with quality of care from a physician or supplier, call 1-800-497-8232 or 406-443-4020.

Qualified Medicare Beneficiary (QMB): If you think you qualify, call 406-444-4540.

Supplemental Insurance questions for federal employees, call 1-800-634-3569 or 406-791-4100.

Travelers Medicare: (Railroad Retirement) Your Medicare number will have an alpha character before your Social Security number. Call 1-800-833-4455.

United Mine Workers: Call 1-800-843-8109

Some of the insurance companies approved to sell Medicare supplement policies in the state of Montana did not return our questionnaire in time for this printing. The following is a list of those companies and the policies they are currently approved to sell in the state of Montana

<u>Company</u>	<u>Policies</u>
Academy Life Insurance Company	A B C
Allianz Life Insurance Company of North America	A B C D E F G H I J
American Integrity Insurance Company	A B C D E H
Bankers Multiple Life Insurance Company	A B C D E F G H I J
Continental Life & Accident Company	A B C F
Hartford Life & Accident Insurance Company	A B C D E F G H I J
Hartford Life Insurance Company	A B C D E F G H I J
Investors Insurance Corporation	A C F
Life Investors Insurance Company of America	A B C D E F G H I J
Midwestern United Life Insurance Company	A B C F
Provident Life & Accident Insurance Company	A C
Reserve National Insurance Company	A B C
United Commercial Travelers of America	A B

The following companies offer policies to people who are less than 65 years old and are on Medicare by reason of disability. The Montana Comprehensive Health Association also offers a Medicare Supplement policy to individuals who cannot get insurance coverage. The individual must have been turned down by two companies before becoming eligible for MCHA coverage.

MEDICARE SUPPLEMENTS FOR THOSE UNDER AGE 65

Aid Association for Lutherans (*for Lutherans only*)
4321 N. Ballard Rd.
Appleton, WI 15499
800-225-5225

American Family Life Assurance Company of Columbus
P.O. Box 1459
Columbus, GA 31902
800-992-3522

Bankers Life and Casualty Company
222 Merchandise Mart Plaza
Chicago, IL 60654-2001
800-621-3724

Pyramid Life Insurance Company
6201 Johnson Drive
P.O. Box 722
Shawnee Mission, KS 66201
913-722-1110

United American Insurance Company
P.O. Box 810
Dallas, TX 75221
214-328-2841

Montana Comprehensive Health Association
404 Fuller Avenue
Helena, MT 59601
406-444-8305
1-800-447-7828 extension 8537

BUYERS' CHECKLIST

The majority of insurance companies and agents are highly ethical. A few, however, are not. Not all of the following activities are illegal or unethical. However, after reviewing this checklist, if you think an agent has acted improperly, please contact the following:

MONTANA INSURANCE DEPARTMENT

Policyholder Services Bureau

P.O. Box 4009

Helena, MT 59604

Phone: (406) 444-2040

Toll-Free Number 1-800-332-6148

1. Did the agent try too hard to convince you of the possibility of you becoming bankrupt; or your plans for retirement being disrupted; or your savings and that of your children or relatives being wiped out because of an extended illness?
2. Did the agent lead you to believe he or she was a representative of the Medicare program, Insurance Department, or other government agency?
3. Did the agent suggest you drop a policy you already have in order to buy the policy he or she was selling?
4. If you have already purchased a policy from an agent, has that agent changed companies and suggested you change your policies over to one offered by the agent's new company?
5. Did the agent suggest you falsify any information on the policy?
6. Did the agent discourage you from shopping around or checking out the policy thoroughly before deciding whether to buy it? Did he or she make you feel like you had to sign up the same day?
7. Did the agent ask you to pay in cash or make your check out to him or her personally or to the agency, instead of to the company?
8. Did the agent fail to explain the policy to you or answer your questions completely?
9. Did the agent complete your health history information on the application exactly as you explained it before you signed the application?

SHOPPING TIPS

Changes in federal law make it easy to shop for Medicare supplement insurance coverage. Before you start comparing policies, follow these five tips:

1. Learn about Medicare's basic coverage and gaps.
2. Study the twelve standard Medicare supplement insurance plans. Decide what coverage would best meet your health needs and financial circumstances.
3. Compare only the policies that meet your needs. Although the benefits are identical for all Medicare supplement insurance plans of the same type, premiums vary widely among companies, and so does the potential for premium increases.
4. Consider your alternatives. If you have limited income and assets, you may qualify for free coverage through other government programs.
5. Contact your state health insurance counseling program for an impartial, free review of your existing coverage.



Don't be a Victim of Insurance Fraud

Common Schemes

- ☐ Overcharging for premiums
- ☐ Collecting annual premiums but submitting only quarterly payments to insurance companies
- ☐ Collecting large, lump-sum premiums from seniors and retaining portions of it in the hope that the seniors die before the misappropriations are noticed by family
- ☐ Not returning refunds from companies to the insured person

To Avoid Becoming a Victim

- ☐ Insist on timely delivery of documents
- ☐ Call the company yourself to confirm coverage
- ☐ Read the documents you receive and ask questions; make agents and companies reply in writing
- ☐ Don't buy unless you understand the policy
- ☐ Know who you are dealing with. Be skeptical of the door-to-door approach.
- ☐ Ask for and use direct billing for premium payments. Don't forward payment to companies through agents if you can avoid it.



DEFINITIONS

In order to make a wise purchase, it is important to become familiar with the terms used by Medicare and Medicare Supplement Policies. You may wish to be familiar with the following terms and concepts:

ASSIGNMENT: The transfer by the policyholder of some or all of his/her rights under a policy to another party. If assignment is noted on the claim form, the insurance company will pay the health care provider directly. Medicare assignment means the provider will accept the Medicare-approved amounts for covered services as payment in full. The beneficiary would then be responsible for any unmet deductible applied to the charge, for the co-insurance, and for any services which were not approved.

CO-PAYMENT: Your portion or percentage of a health expense. For instance, the insurance would pay 80 cents of every dollar on the provider's charges. You pay the other 20 cents. In Medicare, the coinsurance would be based on Medicare-allowable charges.

CONDITIONALLY RENEWABLE: The insurance company will continue insuring you as long as you pay the premium and you continue to meet the terms stated in the policy.

DEDUCTIBLE: The amount of covered expenses you must pay before benefits become payable by the insurers.

EXCLUSIONS OR LIMITATIONS: Specified conditions, circumstances, or services not covered by the policy.

GUARANTEED RENEWABLE: The insurance company agrees to continue insuring you as long as you pay the premium. The company reserves the right to nonrenew all contracts in the state.

MEDICARE-ALLOWABLE CHARGES: The amount deemed reasonable by Medicare for a given medical service. Benefits are based on Medicare-allowable charges which may be less than the provider's charge.

PRE-EXISTING CONDITIONS: A physical condition which existed before the policy became effective. Montana law does not allow Medicare supplement policies to exclude coverage for more than six months after the effective date of the policy, on the grounds a condition existed prior to the effective date of coverage. Companies who replace a Medicare supplement policy must waive the pre-existing waiting period on the replacing policy. If the insured has not completed the waiting period on the first policy, any period of time that was completed must be credited on the new policy. This does not apply to those who have not previously purchased a Medicare supplement policy or to those who have not had a policy within the last 31 days.

The State Auditor's Office attempts to provide reasonable accommodation for any known disability that may interfere with a person's ability to participate in any service, program or activity of the agency. Alternative accessible formats of this document will be provided upon request. For more information, call 406-444-2040, or TDD 406-444-3246.

MARK O'KEEFE

STATE AUDITOR AND COMMISSIONER OF INSURANCE

P.O. BOX 4009

HELENA, MONTANA 59604-4009

TELEPHONE (406) 444-2040 / MONTANA TOLL FREE 1-800-332-6148

INSURANCE INQUIRY/COMPLAINT FORM

In response to your recent request for assistance we are sending our insurance Report Form. Please complete this form and mail to: MARK O'KEEFE, STATE AUDITOR AND COMMISSIONER OF INSURANCE, P.O. Box 4009, Helena, Montana 59604-4009. It often takes several weeks for the Department to complete the review and take appropriate action. You will hear from a Compliance Specialist in writing as soon as the review is completed.

Your Name _____ Phone No. _____

Address _____
(City) (State) (Zip Code)

Date of Birth _____

Social Security # _____

Insurance Company's Name_____

Policy No. _____ Claim No. _____

Kind of Policy: ☐ Auto ☐ Life ☐ Health ☐ Property ☐ Other_____

Agent's name _____ Date of Loss _____

Please indicate which of the following is applicable:

My complaint is against: COMPANY AGENT ADJUSTER

1. ☐ The company has unfairly rejected my claim or has not paid the full benefits to which I am entitled.
2. ☐ The company has delayed processing my claim and I am unable to obtain a response from them concerning it.
3. ☐ The company has not refunded premium moneys that are due me.
4. ☐ I believe the company's action of cancellation or non-renewal of my policy is not justified.
5. ☐ Other _____

Do you have an attorney handling this for you? _____ If not, in your own words, describe your problem. If more space is needed, please add additional sheets. Enclose copies of papers and other correspondence relative to this problem. A copy of this form may be forwarded to the insurance company involved.

Signature _____ Date _____

Use Reverse for Additional Comments

This guide is supported in part by the Health Care Financing Administration, Division of Beneficiary Services, and U.S. Department of Health and Human Services.

Grateful acknowledgment also is extended to the United Seniors Health Cooperative.



MONTANA

5,000 copies of this public document were published at an estimated cost of 60¢ per copy, for a total cost of \$3,000.00, which includes \$3,000.00 for printing and \$.00 for distribution.